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## **Male, Adolescent Suicidality: A literature review.**

### **Abstract**

In the United Kingdom, suicide rates in adolescent males continue to rank consistently and significantly higher than in females. Despite this, suicide prevention strategies within government policies, clinical guidance and practice appear to lack gender specific guidance. Evidence suggests that social constructions of masculinity can influence various factors that contribute to suicidality in this high-risk group. This article reports the results of a literature review, which aimed to inform the development of gender specific guidelines for mental health services to assist in preventing suicidality in adolescent males.

### **Key words**

*Young people, LGBTQ, adolescent, masculinity, suicide prevention, male, suicide.*

For the purpose of this literature review, suicidality refers to any idea, attempt or completion of suicide (Bridge et al., 2006); suicide being 'the act of deliberately killing oneself' (WHO, 2014, pp.17).

According to the World Health Organization (WHO, 2014) adolescence occurs between the ages 10 and 19 years; they also consider that the individuals' biological and social development varies throughout different cultures. Within the UK, Child and Adolescent Mental Health Services (CAMHS) consider those aged between 12 and 18 years as 'young people' within both primary, community and secondary care (NICE, 2005). Meanwhile Erickson (1968) argues that adolescence occurs between the ages of 12 and 18 and is the transition from child to adult. During this transition, Erikson identifies the 'psychological crisis' of 'identity vs. role confusion'. At this stage, social expectations of masculinity can place pressures on adolescents to fit the social norm, leading them to establish a non-genuine character and lack a sense of their true self (Erickson, 1968; Rogers, 1967). Masculinity is a socially constructed term, meaning that from a young age, males are influenced by their social surroundings that evolve their beliefs of what it means to be conventionally masculine. If these, often rigid, expectations are not met then it may negatively impact on these individuals

being socially acceptance by their peers (Women and Gender Advocacy Center, 2018). This can lead to ambiguity, disparity and dissatisfaction in life (Rogers, 1967), which could be implicated in suicidality.

The rate of male suicides between the ages of 10-29 is increasing and is triple the amount of female suicides (Office for National Statistics, 2015). In 2016, Childline's annual review (NSPCC, 2016) reported that calls from young people regarding suicidality had reached a record high. Although the gender of callers is not specified, concerns regarding gender identity and sexuality were responsible for a 47% increase in the provision of counselling sessions. This highlights the impact that gender and sexuality can have on suicidal ideation at this life stage, and the urgent need for further research into prevention strategies.

The WHO (2014) revealed that, globally, young adults living in high-income countries, such as the UK, are the group at highest risk of suicide. Baumeister's (1990) theory suggests that, in males, suicide could be driven by the need to escape from one's self-awareness or as an avoidance of accepting any failures of meeting social expectations, such as traditional masculinity (Scourfield, 2005). Pollock (2006) suggests that males are conditioned from a young age to exhibit typical masculine traits, such as toughness and not expressing vulnerabilities.

The WHO (2014) also recognize the link between the male gender and suicide, possible variant factors include the socially acceptable strategies of coping, which may increase risky behaviors (Pollock, 2006) and result in impulsivity and suicidality in adulthood. But despite evidence suggesting the link between masculinities and suicide, preventative strategies within policy and practice (DoH, 2012; WHO, 2014), and clinical guidance (NICE, 2005) all lack gender specific guidance.

### **Literature search**

A literature search was undertaken with the aim of gaining insight into how mental health services in the United Kingdom can help prevent suicidality in adolescent males. The search terms: 'adolescent males', 'mental health services', 'social constructions of masculinity', 'suicidality', 'suicide

prevention', were used on databases: CINAHL, Ovid MEDLINE, Embase, PsycINFO and Social Policy and Practice. No results were found.

The terminology was adjusted and truncation and Boolean operators were used to narrow the results. The final key words used were: 'adolescent\*', 'masculinity\*', 'suicide prevention' and 'United Kingdom'. Seventy-nine key texts were identified. Any articles where participants who were not of adolescent age or had reference to only females in the abstract were excluded to ensure the focus remained solely on adolescent males. The term 'firearm suicide' was excluded to ensure the geographical focus was the United Kingdom and the availability of the means of suicide were relevant. Articles published prior to 2007 were also excluded, which narrowed the results to the six studies that were included within the literature review.

A thematic analysis of the literature was undertaken to identify key themes and findings (Aveyard and Sharpe, 2013). Twenty themes were identified and were clustered into six key themes: 'conforming to social constructions of masculinity', 'friendships', 'opinions, interpretations and responses to male suicide', 'risk factors', 'protective factors', and 'mental health services'.

### ***Conforming to social constructions of masculinity***

Boys are likely to be set gendered identity expectations from a young age, which can be reinforced at school, consequently placing mental strain on young boys (Mac an Ghaill and Haywood, 2012). Such expectations may lead boys to believe they cannot express fears or worries regarding everyday stressors in adolescent life (Mac an Ghaill and Haywood, 2012). Young men may feel pressured to conform to other typical masculine traits to meet social norms - such as, being independent, heterosexual, successful and high earning, or living with no emotional or psychological problems (Jordan et al., 2012; Sweeney et al., 2014). Not meeting societal expectations may cause low self-esteem (Jordan et al., 2012) and have implications for suicidality (Coleman, 2015; Jordan et al., 2012; Sweeney et al., 2014). Coleman (2015) found that traditional masculinity was an indicator for suicidal ideation, only second to depression. Others may perceive seeking help for emotional or psychological problems as weak, which does not suit the traditional masculine persona (Jordan

et al., 2012; Scourfield et al., 2007). Some boys may feel that they have no other choice but suicide. The highlighted gender expectations that adolescents conform to may influence their preference of suicide method, such as hanging, jumping and drowning, which are more violent, definite means, emulating the socially expected masculine persona (Sweeney et al., 2014; Scourfield et al., 2007).

### ***Friendships***

Gendered differences in friendships were identified (Mac an Ghaill and Haywood, 2012), with boys at school more likely to choose their peers based on how they perceive others reacting in specific scenarios. Despite male friendships being considered valuable (Sweeney et al., 2014), they are more likely to consist of activities that involve victimizing or 'bantering' others (Mac an Ghaill and Haywood, 2012; Sweeney et al., 2014) and less likely to consist of personal, intimate interactions (Sweeney et al., 2014). Despite friends being the only people some boys feel comfortable disclosing personal information to, the lack of supportive interactions may reduce the friend's ability to ascertain how their male friends are truly feeling, thus overlooking the potential signs of suicide (Sweeney et al., 2014). Although some young men may identify with a peer's troubles, they may lack confidence, or be unhelpful, in how they respond to the situation (Sweeney et al., 2014). The emphasis of humour in male friendships may lead to signs of suicidality being missed or not taken seriously (Sweeney et al., 2014). This gendered style of social interaction in the context of friendships means that adolescent males may lack the kinds of protective social network that adolescent females may be more likely to benefit from.

### ***Opinions, interpretations and responses to male suicide***

Despite suicide being considered by young people to be an 'easy' way out, males who commit suicide may be considered to have 'strength' and 'courage' (Scourfield et al., 2007) traditional masculine traits. The shame and sense of failure that may follow an un-successful suicide attempt (Scourfield et al., 2007) may encourage men to ensure subsequent completion of their suicide by the use of more definite means.

Males are thought to be more impulsive and decisive than females, which may contribute to their higher rate of completed suicides (Scourfield et al., 2007). Engaging in risky behaviors is linked to impulsiveness, which may play a part in youth suicide (Sweeney et al., 2014). Adolescents engaging in risky behaviours may be perceived by their peers as 'normal' in context (Sweeney et al., 2014). However, professionals may see risky behaviour as an indicator of suicide. Young men who identify others' behaviour as risky may

lack confidence or knowledge in how to approach the subject to raise those concerns (Sweeney et al., 2014).

Suicidal males are stereotyped to be lonely and isolated (Sweeney et al., 2014). However, some young men who contemplated suicide and did not fit the stereotype, were perceived by friends to be unlikely to harm themselves, owing to their confidence, sporting prowess and apparent social support (Sweeney et al., 2014). This scenario suggests that men assume that typical masculine traits protect someone from suicide, whereas a false front may have actually contributed to their suicide. The male perspective on male suicide could have implications as to why males may feel ashamed to be associated with, and thereby reject access to, mental health services (Sweeney et al., 2014).

### ***Risk factors***

Heterosexuality is believed to be a typical masculine trait (Jordan et al., 2012). From a young age, boys may identify any non-heterosexual behaviours or intimate relationships between two boys as uncomfortable (Mac an Ghaill and Haywood, 2012). A hetero-normative conception of sexuality may lead to homophobic behaviour within the younger population towards anyone acting in a way that is not seen as typically heterosexual (Mac an Ghaill and Haywood, 2012), thus increasing the risk of youth suicide (Button, 2015). When victimized in such a scenario, self-efficacy and self-support can act as protective factors of suicide in heterosexual youth, however, not in those identifying as lesbian, gay, bisexual, trans\* or queer/questioning (LGBTQ) (Button, 2015). Traditional masculinity is known to have a negative impact on suicidality in LGBTQ male youth (Coleman, 2015). As well as the victimization that may be associated with non-conformist sexuality and gender (Pardoe and Trainor, 2017), it was highlighted that failed suicide attempts are perceived as feminine (Scourfield et al., 2007), which may influence the choice of means that those in the LGBTQ population use to decide their fate. These points are important for services to consider should adjustments be made to meet the specific needs of LGBTQ youth.

Life stressors can lead to depression - the largest risk factor for suicidal ideation (Coleman, 2015). Physically or sexually abusive childhoods are also factors that can

influence the risk of suicidality (Coleman, 2015; Jordan et al., 2012), which can be enhanced by the presence of depression (Coleman, 2015). When incorporating traditional masculinity as a factor, childhood sex abuse creates a higher risk of suicidal ideation (Coleman, 2015). Being a victim of violence or abuse can affect a person's sense of power and strength - archetypal masculine traits. This can lead to a lack in confidence and low self-efficacy, which could enhance their risk of suicide.

People use a range of strategies to cope with everyday stress. However, men are more likely to cope by using alcohol, or disclose their difficulties in the context of alcohol (Sweeney et al., 2014). The use of alcohol whilst depressed can significantly increase the risk of suicidal ideation (Coleman, 2015). Men tend to prioritize an easy life (Jordan et al., 2012) and the risk factors highlighted earlier in this discussion may combine to result in a lack of understanding on how to address adverse life events. The disclosure of difficulties when under the influence of alcohol, risks summoning up a shame that is founded on revealing - a trait that does not meet gender expectations - and thus lead to suicidality.

### ***Protective factors***

In heterosexual adolescents, social support and self-efficacy were found to be beneficial and act as a protective factor against suicide (Button, 2015; Jordan et al., 2012). Jordan et al., (2012) highlighted that those who had already attempted suicide found that supportive social environments socializing with survivors of suicide acted as a protective factor against future suicidality. This was owing to the male specific environment that normalized suicide and lacked judgment, giving a sense of belonging to survivors, and allowing them to escape some negative social responses they may have experienced elsewhere.

*It really helped me when my social worker referred me to a support group for young people who were experiencing mental health problems. I realized that other guys felt like I did and it made me feel less weird. "Jack", Suicide Survivor.*



Family members also provide a source of social support (Button, 2015; Jordan et al., 2012), who may be able to identify an adolescent behaving as their 'true self'. Jordan et al., (2012) found that discovering new meaning in life after suicide attempts can be found through family relationships. Self-efficacy can prevent initial suicidality (Button, 2015), but may also prevent further suicidality of those who have made previous 'unsuccessful' attempts (Jordan et al., 2015). It is important for adolescents to acquire their own individual positive outlook and sense of meaning in life to achieve self-efficacy (Jordan et al., 2015). Some adolescents may be fixated on their need to fit within unrealistic social norms and may lack self-efficacy if this aim is not achieved.

Some people feel that considering the possible family grief caused by successful suicides acted as a protective factor of further suicide attempts (Jordan et al., 2012). However, Sweeney et al., (2014) highlights that some adolescents still contemplated suicide, despite acknowledging the grief caused by peers whom previously committed suicide. Some adolescents may or may not be aware of the grief it may cause to loved ones and for some it may act as more of a protective factor than others.

Coleman's (2015) findings showed that amongst young white, traditionally masculine males, positive masculinity ratings had a protective influence on suicidal ideation. This highlights the benefits of achieving a sense of fitting within social norms both objectively and subjectively. It should still be considered that although fitting social norms can act as a protective factor, the risk of not achieving the aim to fit the social norm might outweigh this benefit with its risk identified in the previous section.

### ***Mental health services***

It appears that adolescent males are unaware of sources to help them with their mental health (Jordan et al., 2012). Young men that are struggling may know charities such as 'lifeline'; however, some report they would only contact them as a last resort (Jordan et al., 2012). Current mental health services may be considered discouraging to adolescents ready to seek help, due to their referral process. Jordan et al., (2012) highlighted the need for better outreach services and

advertising that emphasize personal interactions. Current prevention strategies may provide suicidal individuals with encouragement to visit their GP to disclose concerns. However, this may not be what adolescents need, as disclosing concerns may not be encouraged within a 'traditionally masculine' society (Sweeney et al., 2014). GP practices are also perceived as formal and focused on clinical care, with practitioners that form less therapeutic relationships with their patients due to time constraints (Jordan et al., 2012). These aspects of GP practices are perceived by adolescents to be unhelpful and may discourage help-seeking (Jordan et al., 2012). LGBT young people can find articulating their emotional distress overwhelming and frequently prefer to seek help online rather than approaching professional services (McDermott, 2015).

*I dread the prospect of being  
dragged/drugged off to the psychiatric ward.  
I'm not up to telling anyone outside of here  
[online support forum for LGBT youth], the  
real nature of my injuries. "Georgie", cited  
in Pardoe and Trainor (2017).*

Currently in the UK, there are preventative strategies within policy and practice (DoH, 2012; WHO, 2014) and awareness campaigns that encourage men to seek help (The Huffington Post UK, 2017). These interventions, however, may not be effective for this specific risk group and may not address the personal preferences for the development of specific suicide prevention services (Jordan et al., 2012). Therefore, there is impetus for new service development to be proactive, informal, and confidential with less focus on clinical care (Jordan et al., 2012) and more focused on an interactive relationship.

*Someone to talk to, who has training in  
mental illness, but didn't come across as a  
professional. Because [name of counselor]  
and a few others had that knowledge . . .  
but you just sat and talked to him like he  
was your best friend, or one of your mates.  
Suicide Survivor, cited in Jordan et al.  
(2012).*

Sweeney et al., (2014) highlighted the importance for community services to enhance knowledge of suicidality within

adolescent male's social networks to help initiate a 'norm' for openness and responsiveness. This could increase recognition of emotional distress and prevent suicidality being overlooked; help would be encouraged and subsequently sought, and create more opportunity for social support. However, changing social norms could be a lengthy and challenging process. So, short-term initiatives should also be developed more immediately.

Mental health service users were interviewed to explore how their experiences of the service impacted on their recovery from suicidality (Jordan et al., 2012). Cognitive Behavioral Therapy (CBT) was deemed helpful in finding a way to challenge negative perceptions on life and discover a new, realistic meaning in life that was not focused on conforming to social constructions of masculinity.

*The first time, I had, you know, ordinary counselling, whatever you call it, and it was alright. It sort of cleared me up a bit. I had a relapse soon after it though, and the last time, I had CBT, and it worked.*  
Suicide Survivor, cited in Jordan et al. (2012).

The participants had all been actively suicidal at some point in their lives and mental health services were considered an important part of recovering from suicidality. However, the service can be an under-utilized prevention strategy for those who are aware of the service but have not sought help, or for those who are unaware that they need to attend a mental health service. Even though these dimensions of recovery have been deemed successful, it does not take into consideration the problematic factors of accessing services in adolescence and preventing first suicide attempts.

### **Conclusion and Implications for Practice**

There is ample literature that correlates social constructions of masculinity and suicidality. However, there is a paucity of literature that addresses specific prevention strategies for this cohort of people. There is a need for a social shift and for mental health services to provide nurses with expertise on how to incorporate consideration of masculinity into any adolescent male's care. It is evident that the development and implementation of innovative strategies that promote and

maintain a positive construct of one's sense of masculinity is needed. Those encountering this high-risk group should also take into consideration individual family dynamics, sources of social support, sexuality and gender identity to help establish self-efficacy and prevent suicidality.

Males who are not identified to be at risk are often successful in their attempts at suicide. Therefore, future research needs to focus on discovering how to identify those at risk and produce specific strategies to make help-seeking more appealing before crisis. This could include the development of robust online support. It is important to understand what specific aspects of masculinity may impact suicidality in adolescents and feedback from the age group may provide new opportunities for prevention and intervention. The current research identified shows that there are gaps in the knowledge of specific suicide prevention strategies that accommodate and adjust to social constructions of masculinity in adolescent males. There is a need for qualitative feedback on the effectiveness of suicide prevention strategies already in place and what can be done further to adapt these strategies to masculinities and reduce suicide in adolescence within mental health services.

It is important for those involved in caring for adolescent males to consider social constructions of masculinity as a variable in assessment and formulation at both individual and service level, in order to prevent suicide. The dearth of research into the influence of social constructions of masculinity in mental health services to prevent suicidality in adolescent males highlights the need to investigate the matter further. This should inform guidelines and specific suicide prevention strategies to reduce suicidality in this high risk group.

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